NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

April 3, 2019

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Christine M. Radman, Esq.
Bureau of Professional Medical Conduct
NYS Department of Health
90 Church Street
New York, New York 10007

Jeffrey Randolph, Esq.
139 Harristown Road, Suite 205
Glen Rock, New Jersey 07452

Ossama Elbahloul, M.D.
[redacted]

RE: In the Matter of Ossama Elbahloul, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.19-074) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

[redacted]

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH: cmg
Enclosure

STATE OF NEW YORK DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER	:	DETERMINATION
OF	:	AND
OSSAMA ELBAHLOUL, M.D.	:	ORDER
	:	19-074

A Notice of Hearing and Statement of Charges, both dated June 22, 2018, were served upon **OSSAMA ELBAHLOUL, M.D.** (Respondent). **MICHAEL N.J. COLON, ESQ.**, Chairperson, **ELISA J. WU, M.D.**, and **JEFFREY PERRY, D.O.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to § 230(10)(e) of the Public Health Law of the State of New York ("Public Health Law"). Administrative Law Judge **WILLIAM J. LYNCH, ESQ.**, served as the Administrative Officer.

The Department of Health, Office of Professional Medical Conduct ("Petitioner" or "the Department") appeared by **RICHARD J. ZAHNLEUTER**, General Counsel, by **CHRISTINE M. RADMAN, ESQ.**, of Counsel. Respondent was represented by **JEFFREY RANDOLPH, ESQ.** Evidence was received, witnesses sworn and heard, and transcripts of the proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Notice of Hearing Served:	July 3, 2018
Statement of Charges Amended:	August 16, 2018

Pre-Hearing Conference:	September 5, 2018
Answer to Amended Statement of Charges:	September 11, 2018
Hearing Dates:	September 21, 2018 November 13, 2018
Witness for Petitioner:	Samuel Thampi, M.D.
Witness for Respondent:	Ossama Elbahloul, M.D.
Second Amended Statement of Charges:	November 27, 2018
Response to Second Amended Statement of Charges:	January 13, 2019
Written Submissions Received:	February 8, 2019
Deliberations Held:	March 1, 2019 March 13, 2019

STATEMENT OF CASE

On the last hearing day, Respondent admitted during his testimony that he paid a management company a percentage of the income collected by his medical corporation in exchange for furnishing space, personnel, billing and other services. Based on this testimony, the Department made an application for a second amendment to the Statement of Charges, adding a specification of misconduct pursuant to § 6530(19) of the Education Law of the State of New York ("Education Law"). In lieu of scheduling an additional hearing day for further testimony and cross examination on this added specification, Respondent opted to submit a written response. The Second Amended Statement of Charges contains thirty-nine specifications of professional misconduct, as defined in Education Law § 6530. The Department recommends that Respondent's license to practice medicine be revoked. Respondent denies any professional misconduct and asks for dismissal of all the charges against him. A copy of the Second Amended Statement of Charges is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. All findings and conclusions set forth below are the unanimous determinations of the Hearing Committee unless otherwise indicated. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("T."). These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding.

Having heard the testimony and considered the documentary evidence presented by Petitioner and Respondent, the Hearing Committee hereby makes the following findings of fact:

1. Respondent was authorized to practice medicine in New York State on or about May 20, 2008, by the issuance of license number 248705. (Dept. Ex. 2.)

2. Respondent completed his medical education in Egypt in 1982. He worked as a surgeon in Libya, Saudi Arabia and Egypt before coming to the United States in 2000. He did not have the three years of hospital training accredited by the American Council on Graduate Medical Education (ACGME) required for graduates of nonregistered, nonaccredited medical education programs when he applied for New York State licensure in 2007, but the New York State Committee on the Professions accepted his general surgery residency in Egypt, research fellowships at Johns Hopkins and fellowship in the Albany Medical College Renal Transplant Program as its equivalent. (Dept. Ex. 2, pp. 8-21.)

3. From on or about September 9, 2009 through on or about May 22, 2012, Respondent evaluated and treated Patients A through E for their complaints of pain through his solely owned medical corporation, Elbahloul Medical Services, P.C. (Dept. Ex. 3-9.)

4. Respondent has had no formal education and training in Physical Medicine and Rehabilitation (PM&R), pain management, or interventional pain management. (Resp. Ex. B; T. 258-263.)

5. From on or about September 9, 2009 through on or about May 22, 2012, Respondent shared 80% of his fees for professional medical services rendered under his solely owned medical corporation, Elbahloul Medical Services, P.C., based on an agreement with a management company in exchange for rent, equipment and administrative services. (T. 271-273, 354-356.)

6. PM&R is a medical specialty related to the diagnosis and treatment of patients who suffer from injuries and/or medical conditions, resulting in pain and/or some loss of function. (T. 21-23.)

7. Pain management is a subspecialty within PM&R. Interventional pain management is a non-opioid approach to the management of pain which involves the injection of diagnostic/therapeutic agents. When injecting within the spine, imaging guidance and appropriate patient monitoring is required. (T. 20, 25-26.)

8. When a patient presents complaining of pain, a physician must find out the anatomical and pathologic cause of the patient's pain to properly treat that patient, as pain can come from many sources, encompassing muscular-skeletal, neurologic and/or organic systems. (T. 22-24.)

9. The first step in the diagnostic process begins with eliciting an accurate and complete pain history from the patient, which includes asking how long the patient has been in pain, where the pain is, what may have caused it, what makes it better or worse, the quality of the pain (sharp, dull, aching, etc.), whether the pain radiates, if the patient also experiences tingling, numbness and/or weakness, and the severity of the pain (on a scale of 1 to 10). Additionally, it is important to assess whether the patient has had any prior work-up for this condition, whether treatment and/or medication protocols have been undertaken, and if so, what the response has been. (T. 27-30.)

10. Past medical history and a review of symptoms then leads to a physical examination, specifically focusing on the nervous system and corresponding muscular strength, which all together yields a working diagnosis. Absent any concern of infection, tumors, fractures, organ involvement or

emergent neurologic clinical findings, a physician typically begins treatment for the patient's pain conservatively, by prescribing oral anti-inflammatory medications and physical therapy. Further diagnostic testing may be employed within four weeks of the initial evaluation if the patient does not experience improvement. (T. 30-36.)

11. A trigger point injection (TPI) is a procedure in which a local anesthetic is injected into painful areas of muscle in spasm to ease pain. The "knot" area in a muscle is palpated by the physician to determine the site before insertion of the needle and that same area may be injected no more than once every eight weeks. It is important to discern whether a trigger point is a superficial manifestation of a deeper problem. (T. 38-40, 138.)

12. Fluoroscopy is a type of medical imaging that displays a continuous x-ray image on a monitor. It is used to guide certain procedures but carries the risk of radiation exposure which can be harmful to the skin and is carcinogenic. (T. 40-43, 220-221.)

13. There is no medical reason to use fluoroscopy when administering a TPI, as this exposes patients to the risk of radiation without any benefit. The expertise of the medical professional performing the external technique of palpation is all that is necessary. (T. 40, 42-43.)

14. Facet joints are small bilateral joints on the back of the spine between the vertebrae which help support the spine. A facet block injection is generally entirely diagnostic. The procedure involves injecting a longer acting local anesthetic (typically Marcaine for up to eight hours of relief) by fine needle into the area of the nerves supplying those joints to determine whether a patient's pain is coming from a particular facet joint. If a patient experiences relief from the pain, those nerves can be ablated with a heating current to provide six months to two years of pain relief. (T. 43-46.)

15. Facet joint injections must be performed in a sterile environment, with the patient carefully monitored by a trained medical professional throughout the procedure. An anesthesiologist may be

required to administer some sedation. Intravenous access should be obtained as a precaution to address any adverse reactions, and fluoroscopic guidance for needle insertion is necessary to insure accuracy within this small and intricate spinal anatomy. (T. 47-50.)

16. Notwithstanding the significant differences in risk associated with injecting into muscle trigger points versus the posterior aspect of a vertebral joint in the spine, Respondent consistently documented that he used fluoroscopy guidance for the muscle injections but not for the spinal ones. (Dept. Ex. 4-9.)

Patient A

17. Patient A, a then 65-year-old woman, was under Respondent's care from on or about December 1, 2009 through on or about December 6, 2010, initially for neck pain and later for lower back pain. (Dept. Ex. 4, pp. 30-65, Dept. Ex. 5, 5a, and 5b.)

18. Respondent personally certified his medical record for Patient A from January 6, 2010 through July 9, 2010 as "complete, true, and exact copies of the records" for this patient, but billed Patient A's private insurance carrier for seven dates of service and procedures in December of 2009, including facet blocks and an electroencephalogram (EEG), and at least 41 dates of service and procedures after July 9, 2010 through December 6, 2010, including multiple billed facet block procedures, for which no medical record exists. (Dept. Ex. 4, pp. 30, 34-35, 50-63; T. 66-76.)

19. Respondent had no legitimate medical reason to perform an EEG on Patient A (billed at $700), on December 1, 2009, especially since he did not even document an encounter with Patient A on that date. (T. 66-67.)

20. The first documented visit that Patient A made to Respondent was on January 6, 2010. At that visit, Respondent failed to adequately evaluate Patient A for her reported neck and lower back pain in that he did not elicit and/or document an adequate pain history; any medical or surgical history; any medication history or allergies; whether she was a smoker or alcohol abuser; any prior diagnostic testing or treatment;

or any neurologic examination, including reflexes, to determine any sensory deficits and/or muscle weakness. (T. 80-85.)

21. Respondent failed to support his diagnosis of cervical and lumbosacral spondylosis for Patient A's neck and back pain on January 6, 2010 or any time thereafter. Nonetheless, he treated her that very day and multiple times during the next two months with invasive facet block injections which yielded no therapeutic benefit, and he documented no follow-up on the injections which he had purportedly performed. Patient A's lack of pain relief is evidenced by her returning to Respondent two days after her January 6, 2010 visit for the same treatment despite Respondent's recommendation that she return for a re-check in one week, and the pattern continued on January 12, 13, 25, 27, 29 and beyond. (Dept. Ex. 4, pp. 30-63; Dept. 5, pp. 1-9; T. 75, 90-96.)

22. Respondent performed at least eleven facet blocks on Patient A in less than five weeks, between January 6, 2010 and February 12, 2010 injecting short-acting Lidocaine each time, with no indication that he monitored Patient A's condition during the procedures or used imaging guidance when he inserted needles into her spine. Respondent also never documented whether Patient A experienced any pain relief. (Dept. Ex. 4, pp. 1-12; T. 93-94.)

23. These facet blocks exposed Patient A to severe unnecessary risk. This treatment was unwarranted at best and dangerous at worst without a diagnosis. Without IV access and monitoring of vital signs, Patient A was vulnerable if an adverse reaction occurred during her procedure such as an unfavorable response to anesthesia, shock, respiratory distress and/or cardiac arrest. Without the use of imaging guidance during the facet block procedures, Respondent risked inserting the needles improperly into Patient A's discs, nerves, arteries, and/or spinal cord to possibly great adverse effect. (T. 84-90, 132-134.)

24. Respondent failed to either refer Patient A for further diagnostic tests or to a pain management specialist when his care and treatment of her pain was unsuccessful. (T. 96-97.)

25. Between March 8, 2010 and July 9, 2010, Respondent documented that Patient A visited him over thirty times mainly for various strappings. Strapping is the splinting of muscles purportedly to control pain. This intervention is much less effective without directly attempting to control the etiology of the pain. (Dept. Ex. 5, pp. 21-68; T. 129-130.)

26. On March 16, 2010, Respondent documented two office visits for no legitimate medical purpose, when Patient A was seen only once. (Dept. Ex. 5, pp. 23-25; T. 102-103.)

27. On May 12 and May 17, 2010, Respondent documented performing trigger point injections on Patient A under fluoroscopic guidance, unnecessarily exposing the patient to radiation. (Dept. Ex. 5, pp. 47-48; T. 137-138.)

28. Electrodiagnostic studies are performed to compliment a diagnosis in the treatment of pain. They consist of nerve conduction testing and needle muscle testing, taken together. It is not ordered or performed before a patient undergoes a basic neurological examination. Respondent's record for Patient A does not include such examination. (T. 100-101.)

29. On May 21, 2010, Respondent billed Patient A's private insurance carrier for the nerve conduction portion of an electrodiagnostic study, which is not a complete study, with no medical indication, no record, nor any report that would be generated by such a study. Respondent's CV and testimony did not indicate that he received any training or experience in performing electrodiagnostic studies. (Dept. Ex. 4, p. 48; T. 99-102, 174-175.)

30. On August 11, 2010, Respondent documented treating Patient A by strapping her lower back and right and left hips, but he billed her private insurance carrier for more costly trigger point injections

with fluoroscopic guidance. Strapping would not require fluoroscopic guidance. (Dept. Ex. 4, p. 53, Dept. Ex. 5a; T. 99.)

31. Respondent failed to maintain a record that accurately reflects the evaluation and treatment of Patient A based upon the preceding Findings of Fact.

Patient B

32. Patient B, a then 66-year-old man, was under Respondent's care from on or about October 3, 2011 through on or about November 16, 2011, initially for neck pain and later for lower back pain. (Dept. Ex. 4, pp. 23-26; Dept. Ex. 6, pp. 1-5; Dept. Ex. 6a.)

33. Respondent personally certified his medical record for Patient B with five dates of service (October 3, 17, 21 and November 2 and 16, 2011) as "complete, true, and exact copies of the records" for this patient. The services he provided were facet block injections and trigger point injections with fluoroscopic guidance. The billing record for these services show the service location as 420 Lexington Avenue, but Respondent's handwritten notes for each encounter were made under his 160 Broadway letterhead. (Dept. Ex. 4, pp. 23-26; Dept. Ex. 6, pp. 1-5.)

34. Respondent billed Patient B's private insurance carrier for an additional three dates of service and procedures on October 19 and 28 and November 14, 2011, each including trigger point injections with fluoroscopic guidance, for which no medical record exists. (Dept. Ex. 4, pp. 24-26; T. 142-144.)

35. Respondent billed Patient B's private insurance carrier for trigger point injections with fluoroscopic guidance for an October 17, 2011 date of service, for which Respondent documented a handwritten note in Patient B's medical record. This note corresponds to a typewritten operative report sent by Respondent to his insurance company (although the note is dated October 18, 2011). This typed report again carries Respondent's 160 Broadway letterhead while the place of service is listed as 420 Lexington Avenue. The operative note documented the procedure inaccurately as a facet injection (which

he similarly documented incorrectly for the November 10, 2011 trigger point procedure). Respondent billed again for the exact same trigger point procedure again on October 19, 2011, for which no medical documentation exists. (Dept. Ex. 4, pp. 24-26; Dept. Ex. 6, p. 2; Dept. Ex. 6a; T. 150-151.)

36. The first documented visit that Patient B made to Respondent was on October 3, 2011. At that visit, Respondent failed to adequately evaluate Patient B for his reported pain in the ways noted in Finding of Fact #20 for Patient A. Respondent consequently failed to yield a meaningful diagnosis, but nonetheless proceeded to treat the patient with fluoroscopy-guided trigger point injections that very day. Additionally, Respondent failed to document that Patient B was 66 years old at the time, which is important for a differential diagnosis as certain diseases are more prevalent in an older population. (Dept. Ex. 6, p. 1; T. 144-146.)

37. Respondent performed facet blocks on Patient B, injecting short-acting Lidocaine each time, with no indication that he monitored Patient B's condition during the procedures or used imaging guidance when he inserted needles into the patient's spine. Additionally, Respondent never documented that Patient B experienced any significant pain relief. The facet injections exposed the patient to severe unnecessary risk for the reasons articulated in Finding of Fact #23 for Patient A. (Dept. Ex. 6, pp.3-5; T. 149-150.)

38. Respondent documented performing trigger point injections on Patient B under fluoroscopic guidance, unnecessarily exposing the patient to radiation. (Dept. 6, pp. 1-4; T. 147-148.)

39. Respondent failed to maintain a record that accurately reflects the evaluation and treatment of Patient B based upon the preceding Findings of Fact.

Patient C

40. Patient C, a then 67-year-old woman, was under Respondent's care from on or about September 9, 2009 through on or about December 6, 2010, initially for neck and lower back pain and later for knee pain. (Dept. Ex. 4, pp. 6-22; Dept. Ex. 7, p. 63; Dept. Ex. 7a.)

41. Respondent personally certified his medical record for Patient C from March 2, 2010 through December 6, 2010 as "complete, true, and exact copies of the records" for this patient, but he billed Patient C's private insurance carrier for three dates of service and procedures in September of 2009. The services provided were facet block injections for which no medical record exists. Additionally, office visits were billed for June 1, 4, 8 and August 31, 2009 for which no medical record exists. (Dept. Ex. 4, pp. 6, 8, 10-11.)

42. The first documented visit that Patient C made to Respondent was on March 2, 2010. At that visit, Respondent failed to adequately evaluate Patient C for her reported pain in the ways noted in the Findings of Fact #20 for Patient A. Respondent consequently failed to support his diagnosis of thoracic spondylosis, but nonetheless proceeded to strap her thorax and lower back, which intervention is much less effective without directly attempting to control the etiology of the pain. Respondent continued to perform and bill for strapping of Patient C's thorax, lower back, then later, right and left shoulders, right and left hips, and right and left knees "to support the muscles," without any documented diagnostic work-up throughout his treatment. (Dept. Ex. 7, pp. 1-57; T. 129-130, 179-180.)

43. Respondent performed eight facet blocks on Patient C between September 13, 2010 and November 19, 2010, injecting short-acting Lidocaine each time, with no indication that he monitored Patient C's condition during the procedures or used imaging guidance when he inserted needles into her spine. Additionally, Respondent never documented that Patient C experienced any significant pain relief. The facet injections exposed her to severe unnecessary risk for the reasons articulated in the Finding of Fact #23 for Patient A. (Dept. Ex. 7, pp. 32-58; T. 172-173, 175.)

44. Respondent documented performing nineteen trigger point procedures on Patient C from September 17, 2010 through December 6, 2010, under fluoroscopic guidance, unnecessarily exposing her to radiation. (Dept. Ex. 7, pp. 33-63; T. 175-176.)

45. Respondent failed to either refer Patient C for further diagnostic tests or to a pain management specialist when his care and treatment of her pain was unsuccessful. (T. 96-97.)

46. On March 19 and June 18, 2010, Respondent billed Patient C's private insurance carrier for the nerve conduction portions of electrodiagnostic studies, which were not complete studies, for which there was no medical indication (as Respondent did not document even a basic neurological examination of Patient C), no record of the study, nor any report that would be generated by such study. (Dept. Ex. 4, pp. 7, 13; T. 173-175, 182-183.)

47. Respondent failed to maintain a record that accurately reflects the evaluation and treatment of Patient C based upon the preceding Findings of Fact.

Patient D

48. Patient D, a then 64-year-old man, was under Respondent's care from on or about August 19, 2011 through on or about November 14, 2011, initially for neck pain and later for lower back pain. (Dept. Ex. 4, p. 4; Dept. Ex. 8, pp. 1-9; Dept. Ex. 8a.)

49. Respondent personally certified his medical record for Patient D with dates of service from October 7, 2011 through November 9, 2011 as "complete, true, and exact copies of the records" for this patient, but billed Patient D's private insurance carrier for two other dates of service, August 19, 2011 and November 14, 2011. The services he provided were facet block injections. There is no medical record for the November 14, 2011 procedure. (Dept. Ex. 4, p. 4; Dept. Ex. 8, pp. 1-9; Dept. Ex. 8a.)

50. The first documented visit that Patient D made to Respondent was on October 7, 2011. At that visit, Respondent failed to adequately evaluate Patient D for his reported pain in the ways noted in the Finding of Fact #20 for Patient A. Respondent consequently failed to yield a meaningful diagnosis, but he nonetheless proceeded to treat the patient with fluoroscopy-guided trigger point injections that very day. Additionally, Respondent failed to document that Patient D was 64 years old at the time, which is

important for a differential diagnosis as certain diseases are more prevalent in an older population. (Dept. Ex. 8, p.1; T. 144-146.)

51. Respondent performed two facet blocks on Patient D on October 21, 2011 and November 9, 2011 injecting short-acting Lidocaine each time, with no indication that he monitored Patient D's condition during the procedures or used imaging guidance when he inserted needles into the patient's spine. Additionally, Respondent never documented that Patient D experienced any significant pain relief. The facet injections exposed the patient to severe unnecessary risk for the reasons articulated in the Findings of Fact #23 for Patient A. (Dept. Ex. 8, pp. 3, 9.)

52. Respondent documented performing six trigger point procedures on Patient D over the course of one month from October 7, 2011 through November 7, 2011, under fluoroscopic guidance, unnecessarily exposing the patient to radiation. (Dept. Ex. 8, pp. 1-8.)

53. Respondent failed to maintain a record that accurately reflects the evaluation and treatment of Patient D based upon the preceding Findings of Fact.

Patient E

54. Patient E, a man whose age is undocumented in Respondent's medical record, was under Respondent's care from on or about January 11, 2012 through on or about May 22, 2012, initially for neck pain and later lower back pain. (Dept. Ex. 4, pp. 27-29; Dept. Ex. 9, pp. 1-15; Dept. Ex. 9a.)

55. Respondent personally certified his medical record for Patient E with fifteen dates of service as "complete, true, and exact copies of the records" for this patient. The services provided were facet block injections and trigger point injections with fluoroscopic guidance. The billing record for these services show the service location as Liberty Square, but Respondent's handwritten notes for each encounter with Patient E were made under his 160 Broadway letterhead. (Dept. Ex. 4, pp. 27-29; Dept. Ex. 9, pp. 1-15.)

56. Respondent billed Patient E's private insurance carrier $1500 for facet block procedures on February 22, 2012, for which no medical record exists. Respondent performed, documented and billed for the identical procedures on Patient E the day before. (Dept. Ex. 4, p. 28; T. 228-229.)

57. Respondent billed Patient E's private insurance carrier for facet blocks on January 11, 2012, for which Respondent documented a handwritten note in Patient E's medical record which corresponds to a typewritten operative report sent by Respondent to Patient E's private insurance carrier. (Dept. Ex. 4, p. 27; Dept. Ex. 9, p. 1; Dept. Ex. 9a; T. 229-230.)

58. The first documented visit that Patient E made to Respondent was on January 11, 2011. At that visit, Respondent failed to adequately evaluate Patient E for his reported pain in the ways noted in the Finding of Fact #20 for Patient A. Respondent consequently failed to support his diagnosis of cervical and lumbar spondylosis, but he nonetheless proceeded to treat the patient with facet block injections beginning that very day. Additionally, Respondent failed to document Patient E's age in the medical record at any time which is a deviation from the standard of care. (Dept. Ex. 9, p. 1; T. 231.)

59. Respondent's operative note for the first facet injections he performed on Patient E documents a pre-operative diagnosis involving his lower back, but the post-operative diagnosis, inconsistently, relates to the patient's neck. Additionally, Respondent's report documents a facet injection in the uppermost cervical vertebrae at C1-C2, which is rarely done, especially without IV sedation, monitoring and imaging guidance due to the unique dangers such a procedure poses to a patient. (Dept. Ex. 9a; T. 237-244.)

60. Respondent performed fourteen facet blocks on Patient E in four months, injecting short-acting Lidocaine each time, with no indication that he monitored Patient E's condition during the procedures or used imaging guidance when he inserted needles into the patient's spine. Additionally, Respondent never documented that Patient E experienced any significant pain relief. The facet injections

exposed the patient to severe unnecessary risk for the reasons articulated in the Finding of Fact #23 for Patient A. (Dept. Ex. 9, pp. 1-15; T. 231-232.)

61. Respondent documented performing trigger point injections on Patient E on May 9, 2012, under fluoroscopic guidance, unnecessarily exposing the patient to radiation. (Dept. Ex. 9, p. 14; T. 233.)

62. Respondent failed to maintain a record that accurately reflects the evaluation and treatment of Patient E based upon the preceding Findings of Fact.

CONCLUSIONS OF LAW

As required by PHL § 230(10)(f), the Hearing Committee based its conclusions on whether the Department met its burden of establishing that the allegations contained in the Statement of Charges were more probable than not. When the evidence was equally balanced or left the Hearing Committee in such doubt as to be unable to decide a controversy either way, then the judgment went against the Department (See Prince, Richardson on Evidence § 3-206). Having considered the complete record in this matter, the Hearing Committee concludes that the Department has established 31 of the 39 specifications contained in the Second Amended Statement of Charges. The sustained specifications include professional misconduct by practicing the profession with gross negligence and gross incompetence, negligence and incompetence on more than one occasion, ordering excessive tests and treatments not warranted by the condition of the patient, fraudulent practice, failing to maintain a record which accurately reflects the evaluation and treatment of the patient, and fee-splitting. The Hearing Committee made these conclusions of law pursuant to the factual findings listed above, and all conclusions resulted from a unanimous vote of the Hearing Committee.

The Department's expert witness was Samuel Thampi, MD, FAAPMR. Dr. Thampi received his medical education in India. He completed a residency in PM&R at St. Vincent's Medical Center followed

by a fellowship in Pain Management at Emory University in Atlanta. He then worked within the current Northwell Hospital System as a pain management specialist for five years before going into private practice. Dr. Thampi is certified by the American Board of Physical Medicine and Rehabilitation in both PM&R and Pain Management and is licensed in New York, Georgia and California. He is currently an attending physician at Kingsbrook Jewish Medical Center in Brooklyn, St. Catherine of Sienna in Smithtown, New York Hospital Queens, and Northwell Plainview Hospital. Dr. Thampi has almost 20 years of clinical experience in his field. His current practice focuses on the non-opioid management of pain, employing therapeutic injections and prescribing physical therapy. The Hearing Committee found that Dr. Thampi had excellent credentials for providing an opinion on the standard of care in this practice area within the medical profession and that his testimony was very credible.

Respondent contended that Dr. Thampi's testimony should be disregarded as merely a personal opinion because Dr. Thampi did not specify the data and criteria supporting his statements. The Hearing Committee rejects this argument because Dr. Thampi established himself as an eminently qualified expert on the standard of care required for Patients A through E and then testified in detail explaining the nature of Respondent's deviations based upon a review of Respondent's own medical records for these five patients.

In his opening statement, Respondent claimed that his own expert would testify that everything Respondent had done was well within the standard of care. However, Respondent then called no expert witness to testify. Instead, Respondent attempted to justify his own actions, but his testimony was not credible at all. Respondent has virtually no expertise in pain management, and he repeatedly evaded answering questions when the Hearing Committee made efforts to clarify his testimony. For example, Respondent's medical record for Patient A showed that Respondent treated the patient with a facet injection on January 6, 2010 with a plan to see her again in one week. When the Hearing Committee

attempted to ascertain why Respondent saw her instead two days later and which cervical facet level had been injected, Respondent's testimony wandered onto vague statements about plans of care, diagnostic procedures and different lumbar locations, but he refused to directly answer why he had seen the patient earlier than planned and whether he should have indicated the injection site with some specificity in the patient's medical record. (T. 420-430.) Another example of Respondent's failure to be forthright in his testimony can be found in the record when the Hearing Committee asked Respondent the simple question of whether he had hospital privileges. Instead of just acknowledging that he did not, he stated, "No, but I can send anybody to the hospital." (T. 342.) Respondent provided no reasonable explanation for the inadequacy of his medical records, the basis for the medical treatments which he purportedly provided, the severe risks which he unnecessarily created, or his pattern of providing treatments which yielded no therapeutic benefit for these patients.

The First through Fifth Specifications charged Respondent with professional misconduct for practicing medicine with gross negligence in his care of Patients A through E, in violation of New York Education Law § 6530(4). Gross negligence is defined as negligence which involves a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequences. Post v State of New York Department of Health, 245 AD2d 985 (3d Dept. 1997). There is no need to prove that a physician was conscious of the impending dangerous consequences of his conduct. Minielly v Commissioner of Health, 222 AD2d 750 (3d Dept. 1995). Respondent's unsafe manner of performing facet block procedures on these five patients posed an unnecessary risk, and his use of fluoroscopy with trigger point injections exposed them to unnecessary radiation. These are serious deviations from acceptable medical standards which presented a risk of potentially grave consequences to his patients. Accordingly, these specifications are sustained.

The Sixth Specification charged Respondent with professional misconduct for practicing medicine with negligence on more than one occasion in his care of Patients A through E, in violation of New York Education Law § 6530(3). Negligence is defined as the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances and involves a deviation from acceptable medical standards in the treatment of patients. In addition to the gross negligence cited above, Respondent's practice of medicine with these patients showed no effort to diagnose the etiology of their pain or treat it. Accordingly, this specification is sustained.

The Seventh through Eleventh Specifications charged Respondent with professional misconduct for practicing medicine with gross incompetence, in violation of New York Education Law § 6530(6), and the Twelfth Specification charged Respondent with professional misconduct for practicing with incompetence on more than one occasion in his care of Patient A through E, in violation of New York Education Law § 6530(5). Incompetence is the lack of the requisite skill to practice medicine safely, and gross incompetence is incompetence that can be characterized as serious, carrying potentially grave consequences. Dhabuwala v State Board for Professional Medical Conduct, 225 AD2d 609 (3d Dept. 1996). Respondent's testimony demonstrated that his grossly negligent care of these five patients was also due to his incompetence because he was completely unable to recognize the ways in which his medical care was deficient and exposed his patients to unnecessary grave risks. This was evidence of Respondent's lack of the knowledge and skill required to practice medicine on multiple occasions. Accordingly, these specifications are sustained.

The Thirteen through Seventeenth Specifications charged Respondent with professional misconduct for ordering excessive tests for Patient A through E, which were not warranted by the condition of those patients in violation of Education Law § 6530(35). As indicated in the findings of fact

above, Respondent repeatedly administered trigger point injections and facet blocks on Patient A through E which were unwarranted. Accordingly, these Specifications are sustained.

The Eighteenth through Twenty-fifth Specifications charged Respondent with professional misconduct for practicing medicine fraudulently in regard to Patients A through E in violation of Education Law § 6530(2). Fraudulent practice is the intentional misrepresentation or concealment of a known fact. As indicated above in the findings of fact, Respondent made no effort to find the etiology of the pain experienced by these patients or to alleviate that pain, and he performed unwarranted tests and treatments for the sole purpose of generating income by billing insurance companies. Respondent claimed that he could not be held responsible for billing practices which he did not condone, but the Hearing Committee did not believe his testimony alleging no awareness of the fraudulent activity. The Hearing Committee further questions whether Respondent actually performed the many facet blocks which he documented or simply injected lidocaine and billed the insurance company for facet blocks. The Hearing Committee inferred Respondent's knowledge of the falsity of these billing records and his intent to deceive based on his pattern of administering treatments with no regard for the results achieved as well as his evasive testimony which attempted to justify these unwarranted treatments that provided no therapeutic benefit to his patients. Therefore, these Specifications are sustained.

The Twenty-sixth through Thirty-third Specifications charged Respondent with professional misconduct for filing false reports in regard to Patient A through E, in violation of Education Law § 6530(21). The Hearing Committee determined that these specifications are duplicative of the eight prior specifications charging the Respondent with fraud. Accordingly, these latter specifications are not sustained.

The Thirty-fourth through Thirty-eighth Specifications charged Respondent with professional misconduct for failing to maintain a record for each patient which accurately reflects the evaluation and

treatment of the patient, in violation of Education Law § 6530(32). A medical record needs to convey objectively meaningful medical information concerning a patient treated to other physicians. Maglione v New York State Dept. of Health, 9 AD2d 522 (3d Dept. 2004). The histories and physicals which Respondent documented for each of these five patients are gravely inadequate and provide no support for Respondent's diagnoses or treatment. Respondent failed his patients in this respect as was clearly demonstrated by his own inability, when testifying, to explain to the Hearing Committee which cervical facet level he had injected while reviewing his own medical record for a patient. Moreover, inadequacies in a physician's medical records has been found to support a finding of negligence on more than one occasion where a relationship between the inadequacies and patient treatment has been shown, as it has been here. Schoenbach v DeBuono, 262 AD2d 820 (3d Dept. 1999); Saunders v Administrative Review Board, 265 AD2d 695 (3d Dept. 1999). As such, these Specifications are sustained.

The Thirty-ninth Specification charged Respondent with professional misconduct for splitting the income generated by his practice of medicine with a management company in exchange for rent, equipment and administrative services, in violation of Education Law § 6530(19). This specification was established by Respondent's own admission during his testimony that he entered into a contract with a management company on May 1, 2009 which continued until September 15, 2012. The management company's fee for providing for rent, equipment and administrative services, including billing and collection, was based on a percentage of the fees collected by Respondent's medical practice. Although Respondent claimed that the management company had defrauded him by submitting bills to insurance companies for services at a separate location without his knowledge, that has no bearing on his having entered into a fee splitting arrangement for his medical practice at the 160 Broadway location. The Hearing Committee also did not believe Respondent's claim that he had obtained the advice of an attorney before entering into a contract with a fee-splitting arrangement. Further, Respondent's claim in his post-hearing

submission that there was no evidence that the contract was ever performed is inconsistent with the hearing record in which Respondent testified about the fee-splitting arrangement as existing from September 2009 until May 2012. The Hearing Committee finds that Respondent's continued practice with the management company at the 160 Broadway location for almost three years was ample evidence that he was an active partner in the fee-splitting contract and received income from that arrangement. Therefore, this specification is also sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee considered the full spectrum of penalties available pursuant to statute, including revocation, suspension, probation, censure, and the imposition of civil penalties. Physicians must comply with the highest ethical standards, and integrity is as important to the practice of medicine as medical competence. The Hearing Committee found that Respondent lacked credibility, showed no remorse for his misconduct and failed to take any responsibility for his actions.

The record shows that Respondent used his medical license to form a corporation which billed for medical services with no regard for his patients and that this pattern consistent throughout the five patient records in this case. Although the management company that Respondent engaged with may have billed for services at another location without his knowledge and consent, there is overwhelming evidence in the record that Respondent was an active participant engaged in the fraudulent practice of medicine at the 160 Broadway location for almost three years, while providing grossly substandard care to his patients. Accordingly, the Hearing Committee concurs with the Department's recommendation that Respondent's license must be revoked.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The First through Twenty-fifth and the Thirty-fourth through Thirty-ninth Specifications of professional misconduct, as set forth in the Statement of Charges are SUSTAINED;

2. Respondent's license to practice medicine is revoked;

3. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at his last known address and such service shall be effective upon receipt or seven days after mailing, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Albany, New York
April 3, 2019

MICHAEL N.J. COLON, ESQ. (CHAIR)

JEFFREY PERRY, M.D.
ELISA J. WU, M.D.

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Ossama Elbahloul, M.D.
[redacted]

APPENDIX I

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

OSSAMA ELBAHLOUL, M.D.

SECOND AMENDED STATEMENT OF CHARGES

OSSAMA ELBAHLOUL, M.D., the Respondent, was authorized to practice medicine in New York State on or about May 20, 2008, by the issuance of license number 248705 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From on or about December 1, 2009 through on or about December 6, 2010, Respondent evaluated and treated Patient A, a then 65-year-old woman, for neck and back pain through his solely owned medical corporation, Elbahloul Medical Services, P.C. (EMS) at 160 Broadway, New York, New York 10038. Respondent deviated from medically accepted standards of care in that he:

1. Failed to perform and document an adequate history and physical examination for Patient A.
2. Diagnosed Patient A with medical conditions unsupported by medically appropriate diagnostic testing.

3. Improperly treated Patient A by performing multiple medically unwarranted trigger point injections and facet blocks, often at intervals of less than one week apart, exposing Patient A to risk.
4. Improperly used fluoroscopy when performing trigger point injections, exposing Patient A to unnecessary radiation exposure.
5. Treated Patient A's spinal pain by improperly performing facet blocks.
6. Billed Patient A's private medical insurance carrier for multiple office visits, strappings and facet block procedures on dates for which there are no medical records of any such visits or procedures.
   a. Respondent did so with intent to deceive.
7. Billed Patient A's private medical insurance carrier for Electrodiagnostic tests on May 21, 2010 for which there is no medical record or report of any such testing.
   a. Respondent did so with intent to deceive.
8. Documented two office visits on March 16, 2010, when Patient A had only one visit.
   a. Respondent did so with intent to deceive.
9. Billed Patient A's private medical insurance carrier for a fluoroscopy guided treatment on August 11, 2010, when Patient A's medical record did not reflect any such treatment.
   a. Respondent did so with intent to deceive.
10. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient A.

B. From on or about October 3, 2011 through on or about November 16, 2011, Respondent evaluated and treated Patient B for neck and back pain through his solely owned medical corporation, Elbahloul Medical Services, P.C. (EMS) at

160 Broadway, New York, New York 10038. Respondent deviated from medically accepted standards of care in that he:

1. Failed to perform and document an adequate history and physical examination for Patient B.
2. Diagnosed Patient B with medical conditions unsupported by medically appropriate diagnostic testing.
3. Improperly treated Patient B by performing multiple medically unwarranted trigger point injections and facet blocks, often at intervals of less than one week apart, exposing Patient B to risk.
4. Improperly used fluoroscopy when performing trigger point injections, exposing Patient B to unnecessary radiation exposure.
5. Treated Patient B's spinal pain by improperly performing facet blocks.
6. Performed intra-muscular trigger point injections on Patient B but documented and/or billed them improperly as facet joint injections.
7. Billed Patient B's private medical insurance carrier for multiple office visits, strappings and use of fluoroscopy on dates for which there are no medical records of any such visits or procedures.
   a. Respondent did so with intent to deceive.
8. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient B.

C. From on or about September 9, 2009 through on or about December 6, 2010, Respondent evaluated and treated Patient C, a then 62-year-old woman, for neck and back pain through his solely owned medical corporation, Elbahloul Medical Services, P.C. (EMS) at 160 Broadway, New York, New York 10038. Respondent deviated from medically accepted standards of care in that he:

1. Failed to perform and document an adequate history and physical examination for Patient C.

2. Diagnosed Patient C with medical conditions unsupported by medically appropriate diagnostic testing.
3. Improperly treated Patient C by performing multiple medically unwarranted trigger point injections and facet blocks, often at intervals of less than one week apart, exposing Patient C to risk.
4. Improperly used fluoroscopy when performing trigger point injections, exposing Patient C to unnecessary radiation exposure.
5. Treated Patient C's spinal pain by improperly performing facet blocks.
6. Billed Patient C's private medical insurance carrier for multiple services on dates for which there are no medical records of any office visits or such procedures.
   a. Respondent did so with intent to deceive.
7. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient C.

D. From on or about August 19, 2011 through on or about November 14, 2011, Respondent evaluated and treated Patient D for neck pain through his solely owned medical corporation, Elbahloul Medical Services, P.C. (EMS) at 160 Broadway, New York, New York 10038. Respondent deviated from medically accepted standards of care in that he:

1. Failed to perform and document an adequate history and physical examination for Patient D.
2. Diagnosed Patient D with medical conditions unsupported by medically appropriate diagnostic testing.
3. Improperly treated Patient D by performing multiple medically unwarranted trigger point injections and facet blocks, often at intervals of less than one week apart, exposing Patient D to risk.

4. Improperly used fluoroscopy when performing trigger point injections, exposing Patient D to unnecessary radiation exposure.
5. Treated Patient D's spinal pain by improperly performing facet blocks.
6. Billed Patient D's private medical insurance carrier for a November 14, 2011 office visit, trigger point injection and use of fluoroscopy, for which there is no medical record of any such visit or procedures.
   a. Respondent did so with intent to deceive.
7. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient D.

E. From on or about January 11, 2012 through on or about May 22, 2012, Respondent evaluated and treated Patient E for neck and back pain through his solely owned medical corporation, Elbahloul Medical Services, P.C. (EMS) at 160 Broadway, New York, New York 10038. Respondent deviated from medically accepted standards of care in that he:

1. Failed to perform and document an adequate history and physical examination for Patient E.
2. Diagnosed Patient E with medical conditions unsupported by medically appropriate diagnostic testing.
3. Improperly treated Patient E by performing multiple medically unwarranted facet blocks, often at intervals of less than one week apart, exposing Patient E to risk.
4. Improperly used fluoroscopy when performing trigger point injections, exposing Patient E to unnecessary radiation exposure.
5. Treated Patient E's spinal pain by improperly performing facet blocks.
6. Billed Patient E's private medical insurance carrier for a facet block procedure on February 22, 2012, for which there is no medical record of any visit or procedure.

a. Respondent did so with intent to deceive.

7. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient E.

F. From on or about September 9, 2009 through on or about May 22, 2012, Respondent shared 80% of his fees for professional medical services rendered under his solely owned medical corporation, Elbahloul Medical Services, P.C., under an agreement with a management company in exchange for rent, equipment and administrative services.

SPECIFICATION OF CHARGES
FIRST THROUGH FIFTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

1. Paragraph A and each of its subparagraphs, except 6 and 6(a), 7 and 7(a), 8 and 8(a), 9 and 9(a) and 10.
2. Paragraph B and each of its subparagraphs, except 7 and 7(a) and 8.

3. Paragraph C and each of its subparagraphs, except 6 and 6(a) and 7.

4. Paragraph D and each of its subparagraphs, except 6 and 6(a) and 7.

5. Paragraph E and each of its subparagraphs, except 6 and 6(a) and 7.

SIXTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of:

6. Paragraph A and each of its subparagraphs, except 6, 6(a), 7, 7(a), 8, 8(a), 9 and 9(a); and/or Paragraph B and each of its subparagraphs, except 7 and 7(a) ; and/or Paragraph C and each of its subparagraphs, except 6 and 6(a); and/or Paragraph D and each of its subparagraphs, except 6 and 6(a); and/or Paragraph E and each of its subparagraphs, except 6 and 6(a).

SEVENTH THROUGH ELEVENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

7. Paragraph A and each of its subparagraphs, except 6, 6(a), 7, 7(a), 8, 8(a), 9, 9(a) and 10.

8. Paragraph B and each of its subparagraphs, except 7, 7(a) and 8.

9. Paragraph C and each of its subparagraphs, except 6, 6(a) and 7.

10. Paragraph D and each of its subparagraphs, except 6, 6(a) and 7.

11. Paragraph E and each of its subparagraphs, except 6, 6(a) and 7.

TWELFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of:

12. Paragraph A and each of its subparagraphs, except 6, 6(a), 7, 7(a), 8, 8(a), 9 and 9(a); and/or Paragraph B and each of its subparagraphs, except 7 and 7(a); and/or Paragraph C and each of its subparagraphs, except 6 and 6(a); and/or Paragraph D and each of its subparagraphs, except 6 and 6(a); and/or Paragraph E and each of its subparagraphs, except 6 and 6(a).

THIRTEENTH THROUGH SEVENTEENTH SPECIFICATIONS

UNWARRANTED TESTS/TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(35) by ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient, as alleged in the facts of:

13. Paragraphs A and A (3).

14. Paragraphs B and B (3).

15. Paragraphs C and C (3).

16. Paragraphs D and D (3).

17. Paragraphs E and E (3).

EIGHTEENTH THROUGH TWENTY-FIFTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

18. Paragraphs A, A (6) and A(6)(a).

19. Paragraphs A, A (7) and A(7)(a).

20. Paragraphs A, A (8) and A(8)(a).

21. Paragraphs A, A (9) and A(9)(a).

22. Paragraphs B, B (7) and B(7)(a).

23. Paragraphs C, C (6) and C(6)(a).

24. Paragraphs D, D (6) and B(6)(a).

25. Paragraphs E, E (6) and E(6)(a).

TWENTY-SIXTH THROUGH THIRTY-THIRD SPECIFICATIONS

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by willfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

26. Paragraphs A, and A (6).

27. Paragraphs A and A (7).

28. Paragraphs A and A (8).

29. Paragraphs A and A (9).

30. Paragraphs B and B (7).

31. Paragraphs C and C (6).

32. Paragraphs D and D (6).

33. Paragraphs E and E (6).

THIRTY-FOURTH THROUGH THIRTY-EIGHTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

34. Paragraphs A and A (10).

35. Paragraphs B and B (8).

36. Paragraphs C and C (7).

37. Paragraphs D and D (7).

38. Paragraphs E and E (7).

THIRTY-NINTH SPECIFICATION

SHARING FEES FOR PROFESSIONAL MEDICAL SERVICES WITH NON-PRACTITIONERS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(19) by permitting a person or persons, not authorized by New York State Education Law, to share in the fees for his professional medical services in exchange for rent, equipment and administrative services, as alleged in the facts of:

39. Paragraph F.

DATE November 27, 2018
New York, New York

HENRY WEINTRAUB
Chief Counsel
Bureau of Professional Medical Conduct